

State of Maine
Department of Health and Human Services (DHHS)
Application For

MaineCare and Food Stamp Benefits

Return to:

Application for: ☐ MaineCare – Full Benefits ☐ Medicare Buy-In Only
☐ Low Cost Drugs (DEL) / MaineRx Plus ☐ Food Stamps
☐ MaineCare Limited Benefits Program

Do you have a physical or mental health condition that keeps you from working full or part time? ☐ Yes ☐ No

Your name (first, middle initial, last)		Maiden Name	Social Security number	Sex
Birth date (month/day/year)	Place of birth		Your Medicare claim number (if any)	

Mailing address:

Street, PO Box, or RR (include apartment number, in care of, etc.)			Is this a safe delivery address? <input type="checkbox"/> Yes <input type="checkbox"/> No	
City	State	Zip Code	Phone	
If different from your mailing address, give the address where you actually live:				

You need to answer only the questions for the program(s) you are applying for.

For Food Stamps Only: To file this application now, we need your name (or that of an authorized representative), address and signature. If eligible, your benefits will begin from the date DHHS gets a signed application.

You may be eligible for Food Stamps benefits right away:

- does your monthly income and cash/money in a bank add up to less than your monthly living expense? _____
- is your monthly income less than \$150 and cash/money in a bank less than \$100? _____
- are you a migrant worker and your income has stopped? _____

Social Security numbers are used to do computer matches with I.R.S., BMV, IFW, the Social Security Administration, Department of Labor, other government agencies and private financial institutions. DHHS and federal officials may check with other sources to prove the information you give.

If you give wrong information, you may be charged with giving false information.

I understand the questions on this form. I certify, under penalty of perjury, that all my answers are correct and complete as far as I know, including those concerning citizenship and alien status for each person applying for benefits. I understand DHHS has the right to collect from other available insurance or from settlement(s) for accidents or injuries whenever MaineCare pays for Medical Expenses.

Signature of person applying _____ Date _____

Signature of person filling out this form _____ Date _____

If you have someone who knows your situation, and you want us to contact them to help with this application, please complete the following:

Name _____ Address _____
Telephone _____

For office use only:	
Received _____	45 th day _____ -
Residency _____	ID _____
Food Stamp Expedite <input type="checkbox"/> Yes <input type="checkbox"/> No	

ARE YOU: <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated (Check only one box)	If you live with your spouse: Spouse's name _____ (first, middle initial, last) Date of birth _____ Sex _____ Able to work? <input type="checkbox"/> Yes <input type="checkbox"/> No (month /day/year) Place of birth _____ Maiden name _____ Spouse's Social Security number _____ Spouse's Medicare claim number _____
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Last name	First name	Middle Initial	Sex	Birth -date	Social Security Number	Relationship to you

Source	Yourself	Your spouse (who lives with you)	Other family members (please list amount and name of member)
Social Security	\$	\$	\$
SSI	\$	\$	\$
Other Income or Pensions (such as railroad retirement, interest, dividends, etc., please explain)	\$	\$	\$

Name	Employer's name and phone number	Gross Amount earned	How often are you paid	Hours worked each week

• Checking or Savings Account • Credit Union Shares • IRA, 401K, Keogh • Certificate of Deposit • Other Accounts • Profit Sharing • Safety Deposit Box • Assets Owned with Others • Stocks • Annuities • Prepaid Burials • Trusts				
Name(s) on account	Type of asset (see above)	Name of bank or institution	Account number	Current balance or value

List life insurance owned by yourself and/or your spouse (who lives with you):

Owner	Company name and address	Face value	Cash value

Do you or anyone in your household own any land, buildings, time shares or jointly held real estate, including where you live? ☐Yes ☐No If YES, list below:

Owner	Type of real estate

Does anyone in your household own any cars, trucks, boats, campers, motorcycles, snowmobiles, ATV's, trailers, tractors, or other motorized vehicles? ☐Yes ☐No If YES, list below:

Year	Make	Model	Owner	Used for	Amount owed

Did you give away anything in the last 3 months? ☐Yes ☐No

Does anyone who is applying have health insurance? ☐Yes Who? _____; ☐No

Are you requesting help with medical bills incurred within the last three months?

☐Yes ☐No Which months? _____

Did you or anyone in your household serve in the U. S. military? ☐Yes ☐No

In which branch of the military did you serve? _____

When did you serve? (dates) _____ to _____

Did you serve on foreign soil? ☐Yes ☐No

Are you receiving VA benefits that include payment of prescription drugs? ☐Yes ☐No

Estate Recovery:

If you receive benefits from MaineCare after age 55, and certain conditions exist, the Estate Recovery Program will make a claim against the assets of your estate to recover money MaineCare has paid for your care. Estate assets can include real property, including jointly owned property, insurance payments, annuities, any property left to an heir, survivor or assignee. No claim will be made if the only service you receive is the Medicare Buy-In. For more information about the Estate Recovery Program, call 1-800-572-3839.

Please complete a section for each adult applying for benefits. This information is Voluntary. Your benefits <u>will not</u> be affected if you do not answer.	Applicant	Second Adult
Are you Hispanic or Latino?	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
Are you an American Indian or Alaskan Native?	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
Circle the tribe you belong to: 1. Houlton Maliseet 2. Peter Dana Pt. Passamaquoddy 3. Pleasant Point Passamaquoddy 4. Penobscot 5. Aroostook Micmac 6. Other		
Do you live on your tribe's reservation?	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
Are you Asian?	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
Are you Black or African American?	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
Are you Native Hawaiian or Pacific Islander?	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
Are you White?	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>

Fill out the rest of this form only if you are applying for Food Stamps

Please list your shelter costs (do not list past due amounts or security deposits).

Rent _____	How often _____	Electricity _____	How often _____
Mortgage _____	How often _____	Telephone (basic) _____	How often _____
Property taxes _____	How often _____	Cooking fuel _____	How often _____
House insurance _____	How often _____	Water _____	How often _____
Condo fees _____	How often _____	Sewer _____	How often _____
Heat _____	How often _____	Trash collection _____	How often _____

If you rent, is your heat included in your rent? ☐Yes ☐No

If you pay a mortgage, are taxes and insurance included in your payment? ☐Yes ☐No

Has anyone received HEAP fuel assistance since last October? ☐Yes ☐No

Have you moved since last October? ☐Yes ☐No

Have you received help with these expenses from the town or city in the last 6 months? ☐Yes ☐No

Does anyone else help pay part or all of these bills? ☐Yes ☐No

If yes, who has helped you? _____

How many people, including yourself, live in your home and purchase and prepare meals with you? _____

Is anyone in your household a migrant or seasonal farm worker? ☐Yes ☐No

If anyone in your household is 60 or older or receiving disability benefits, do they pay over \$35/month for their medical expenses, such as health insurance (including Medicare), over the counter or prescription medicines, doctor or dentist bills, hearing aids, eye care, transportation and other medical services? ☐Yes ☐No If yes, please list and provide proof of these expenses.

Is anyone you are applying for a foster child, in state custody or a boarder ☐Yes ☐No If yes, who?

Are you paying someone to care for a child or disabled adult? ☐Yes ☐No

Who do you pay? _____ How much do you pay? _____ How often? _____

Is anyone on strike? ☐Yes ☐No Who? _____

Has anyone committed an Intentional Program Violation for Food Stamps ☐Yes ☐No Who?

Has anyone quit a job in the last 60 days? ☐Yes ☐No Who? _____

Does anyone pay child support? ☐Yes ☐No Who? _____ How much? _____

How often? _____ To whom? _____ For whom? _____

Is any household member fleeing to avoid prosecution or jail for a felony or violation of probation or parole?

☐Yes ☐No

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